

REC'D JUN 13 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

18570
Do not use this space.

1. PLACE OF DEATH

(a) County **FRANKLIN** Registration District No. **295**
 (b) Township **BOONE - S.** Primary Registration District No. **5415A** Registered No. **27**
 (c) City..... (d) Street No..... (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred **21** yrs. mos. ds. (f) How long in U. S., if of foreign birth? **file no 3** yrs. mos. ds.

2. PRINT FULL NAME

520 HENERY T. LONG
 (a) Residence, No. **Sullivan, Mo. R. R. #** St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widower**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Sarah M. Long**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **August 22, 1860**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 8 17

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Farmer**
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) **1937** 11. Total time (years) spent in this occupation **Life**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **West Plains Missouri**

FATHER 13. NAME **Isaac Long**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Tennessee.**

MOTHER 15. MAIDEN NAME **Unknown**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

17. INFORMANT (ADDRESS) **Elijah Long Sullivan, Mo.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Crow Cemetery** DATE **May 11, 1939**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Thos. P. Shaffer Sullivan, Mo.**

20. FILED **5-11 1939** **Ch. [Signature]** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **May 9, 1939**

22. I HEREBY CERTIFY, That I attended deceased from **5-6 1939** to **5-9 1939**
 I last saw him alive on **5-8 1939** Death is said to have occurred on the date stated above, at **3 A.** m.
 The principal cause of death and related causes of importance were as follows:

Hypertensive pneumonopathy
 Date of onset **5-6-39**
 Other contributory causes of importance: **pac. left hip**
eye red since that time -
Jan 1938

Name of operation **None** Date of.....
 What test confirmed diagnosis **clinical** Was there an autopsy? **NO.**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.
at home
 Manner of injury **Fell at home**
 Nature of injury **pac. left hip**

24. Was disease or injury in any way related to occupation of deceased? **no.**
 If so, specify..... (Signed) **Ch. [Signature]** M. D.
 (Address) **Sullivan, Missouri.**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Edgar W. Lef

Licensed Embalmer No. 3374

P. O. Address Sullivan

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH JAN 24 1940

(a) County..... Franklin Registration District No. 275 1104

(b) Township..... Boone Primary Registration District No. 54 15A Registered No. 25

(c) City..... (d) Street No.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred 21 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Henry I. Long

(a) Residence, No. Sullivan Mo R R St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah M Long

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 22 1860

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, hrs. or min. |
|-----------|----------|-----------|------|----------------------------------|
| <u>78</u> | <u>8</u> | <u>17</u> | | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. farmer

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 1937 11. Total time (year) spent in this occupation life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Plains Missouri

FATHER

13. NAME Isaac Long

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER

15. MAIDEN NAME unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) Elijah Long, Sullivan Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Cross Cemetery May 11 37

19. FUNERAL DIRECTOR (ADDRESS) J. P. Shaffer Sullivan Mo

20. FILED 1-13-40 Chas A. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 9 39

22. I HEREBY CERTIFY, That I attended deceased from 5-6-39 to 5-9-39

I last saw him live on 5-8-39, 1939. Death is said to have occurred on the date stated above, at 3A m.

The principal cause of death and related causes of importance were as follows:

hypostatic pneumonia

Date of onset 5-6-39

Other contributory causes of importance: fract. left hip in bed since that time Jan 1938

Name of operation none Date of

What test confirmed diagnosis? Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury , 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. at home

Manner of injury fall @ home

Nature of injury fract left hip

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Q A Procter, M. D.
(Address) Sullivan Mo

